STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155516	A. BUILDING 00 B. WING	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MEMORIAL HOSPITAL-CCC	2200 RANDALLIA DR FORT WAYNE, IN 46805

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F0000	This visit was for the Recertification and State Licensure Survey. Survey Dates: May 9, 10, and 11, 2012 Facility Number: 001203 Provider Number: 155516 AIM Number: N/A Survey Team: Julie Wagoner, RN-TC Christine Fodrea, RN Tim Long, RN Census Bed Type: SNF: 25 Total: 25 Census Payor Type: Medicare: 12 Other: 13 Total: 25 Sample: 10 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on May 16, 2012, by Bev Faulkner, RN	F0000	This Plan of Correction constitutes our allegation of compliance.Please consider this Plan of Correction to meet the requirements of paper compliance versus an on site re-survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interviews, the facility failed to ensure a physician's order to obtain stool samples for occult blood testing was followed for 1 of 10 residents reviewed for physician's orders (#14) in a sample of 10. Finding includes:	F0282	Plan of Correction F 282 1.Resident #14 was unable to provide another specimen prior to her discharge on 5-11-2012. 2.All other resident orders were reviewed and there were no other residents on the unit that had orders for hematest stools. 3.Process was developed for ordering, collecting and communicating specimens needed for testing. (See document #1) 4.Educator will inservice staff regarding ordering, collecting and communicating specimens needed for testing. (See document #2) 5.Quality Monitoring: 1.Monthly QI monitoring/data collection form was developed. (See document #3) 2.ADON will monitor all hematest stool orders each month. 3.QI monitoring results will be trended, reported, discussed and follow up initiated at QI meetings. 4.QI Team will determine when monitoring can be decreased to quarterly when 100% compliance is reached, not less than six months of observation.	06/08/2012

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	1. Resident #14's record was reviewed 5-9-12 at 8:45 p.m. Resident #14's diagnoses included but were not limited to diabetes, high blood pressure, and multiple sclerosis. A physician's order, dated 5-5-2012 at 9:55 a.m., indicated a stool for hemetest (a testing of a stool sample to see if blood is present) was to be performed 3 times. A review of the ADL summary indicated Resident #14 had a medium incontinent stool on 5-5 between 8 p.m. and midnight. There was no indication the stool was hemetested. A review of the ADL summary indicated Resident #14 had a large incontinent stool on 5-6 between noon and 6 p.m. There was no indication the stool was hemetested. A review of the ADL summary indicated Resident #14 had a medium incontinent stool on 5-6 between 8 p.m. and midnight. The stool was hemetested negative. A review of the ADL summary indicated Resident #14 had a medium incontinent stool on 5-7 between 8 p.m. and midnight. There was no indication the stool was hemetested.	F0282	Plan of Correction F 282 1.Resident #14 was unable to provide another specimen prior to her discharge on 5-11-2012. 2.All other resident orders were reviewed and there were no other residents on the unit that had orders for hematest stools. 3.Process was developed for ordering, collecting and communicating specimens needed for testing. (See document #1) 4.Educator will inservice staff regarding ordering, collecting and communicating specimens needed for testing. (See document #2) 5.Quality Monitoring: 1.Monthly QI monitoring/data collection form was developed. (See document #3) 2.ADON will monitor all hematest stool orders each month. 3.QI monitoring results will be trended, reported, discussed and follow up initiated at QI meetings. 4.QI Team will determine when monitoring can be decreased to quarterly when 100% compliance is reached, not less than six months of observation.	06/08/2012

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	A review of the ADL summary indicated Resident #14 had a hard formed stool on 5-8 between 8 p.m. and midnight. There was no indication the stool was hemetested. In an interview on 5-10-2012 at 1:38 p.m., RN #1 indicated it was difficult to obtain hemetests on incontinent stool because of possible contamination, but the hemetest should have been obtained on the formed stool on the 8th. A policy and procedure titled, "Occult Blood Stool Collection (Hemoccult Sensa)" dated 07-2009 indicated physicians could elect to complete testing without placing the patient on diet and drug guidelines. The policy did not indicate any other reason to refrain from completing the test. 3.1-35(g)(2)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure there was an air gap for the drainage part of the ice machine. This had the potential to affect all residents residing in the Continuing Care Center unit. Finding includes: During the environmental tour, conducted on 05/10/12 between 1:45 P.M. - 2:30 P.M., the ice machine was noted to be in the west hall lounge. The Housekeeping Supervisor, employee #8, indicated the ice machine was new. A copper-colored 1 inch drainage pipe was noted to extend about 6 inches from the back of the ice machine, curve downwards into a metal collection box. The tip of the copper pipe was noted to be touching the top edge of the metal collection box situated behind the ice machine. There was no visible gap located between the bottom of the drainage pipe and the top of the collection box.	F0371	Plan of Correction F 0371 1. Employee #9 reviewed manufacturer installation instructions for the ice machine on 5 West. The ice machine was installed according to the instructions; however there was no documentation an air gap or back flow prevention valve was built into the drainage portion of the ice machine. 2. Employee #9 evaluated the ice machine on 5 East and verified it did have a 1" air gap at the drain. 3. Employee #9 modified the copper tubing and drain box to accommodate the required 1" air gap at the drainage portion of the ice machine. 4. Quality Monitoring: The ice machine has been modified to meet the 1" air gap requirement at the drain. This does not need to be reviewed via the monthly QI process since the repair is complete.	05/11/2012

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	Interview with the Housekeeping Supervisor, Employee #8 and a Maintenance Worker, Employee #9 indicated they thought the ice machine had a "built in air gap" inside the machine. However, interview, on 05/11/12 at 9:30 A.M., and review of the manufacturer's instructions for the ice machine indicated a "back flow" valve was built in to the water inlet part of the ice machine, but there was no documentation an air gap or back flow prevention valve was built into the drainage portion of the ice machine. 3.1-21(i)(2)			

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on record review and interview, the facility failed to ensure 2 of 10 residents	F0441	Plan of Correction F 441 1.Resident #20: An order was	06/08/2012

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	(#20, 4) reviewed for tuberculin skin testing had their skin tests read between 48-72 hours after administration in a sample of 10. Findings include: 1. Resident #20's clinical record was reviewed on 5/10/12 at 7:35 A.M. The record indicated the resident was admitted to the facility on 5/1/12 and a tuberculin skin test was administered on 5/1/12. Review of the resident's record did not indicate the tuberculin skin test was read between 48-72 hours after administration.. An interview with RN #5 on 5/10/12 at 11:30 A.M., indicated the tuberculin skin test was administered on 5/1/12 in the resident's left forearm and was to have been read on 5/4/12. RN #5 indicated the tuberculin skin test was not read on 5/4/12. 2. Resident #4's clinical record was reviewed on 5/11/12 at 10:00 A.M. The record indicated the resident was administered a first step tuberculin skin test on 3/28/12 and read on 3/31/12 and was 0 millimeter's induration. Resident #4 received a second step tuberculin skin test on 4/18/12. The record indicated the second step tuberculin skin test was not		obtained on 5-10-12 to repeat the test. It was given on 5-10-12 at 1316 and it was read on 5-13-12 at 0900. 2.Resident # 4: Was discharged on 5-16-2012 3.All other resident Mantoux orders were reviewed and verified that reads were completed or read date was correctly entered in orders. 4.Mantoux give/read process was clarified. (See document #4) 5.A Mantoux Give/Read Follow Up Form was developed and will be completed for every new admission. (See document #5) 6.Educator will inservice staff regarding Mantoux Give/Read Process. (See document #2) 7.Quality Monitoring: 1.Monthly QI monitoring/data collection will be monitored from the Mantoux Give/Read Follow Up form. 2.ADON will monitor all Mantoux give/read as they are added to the form from the admission nurse. 3.QI monitoring results will be trended, reported, discussed and follow up initiated at QI meetings. 4.QI Team will determine when monitoring can be decreased to quarterly when 100% compliance is reached, not less than six months of observation.	

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	read between 48-72 hours. An interview with the Director of Nursing on 5/11/12 at 12:15 P.M., indicated the resident's second step tuberculin test was not read between 48-72 hours after administration. Review of the facility policy titled "Tuberculosis Assessment and Screening" origination date 4/1994, last reviewed 1/2012, indicated the following: "1.C. A Mantoux test (5TU PPD) completed within three months prior to admission or administered upon admission and read at 48-72 hours." The procedure indicated "II. A. The baseline tuberculin skin testing should employ the two-step method. B. For residents who have not had a documented negative tuberculin skin test result during the preceding 12 months, the baseline tuberculin skin testing should employ the two step method. If the fist step in negative, a second test should be performed within 1 to 3 weeks after the first test." 3.1-18(e)			

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F0502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on interview and record review, the facility failed to ensure stool specimens and hemetests as ordered by the physician were obtained for 1 of 8 residents reviewed for lab test completion in a sample of 10 (Resident #14). Findings include: Resident #14's record was reviewed 5-9-12 at 8:45 p.m. Resident #14's diagnoses included but were not limited to diabetes, high blood pressure, and multiple sclerosis. A physician's order, dated 5-5-2012 at 9:55 a.m., indicated a stool for hemetest (a test where a stool sample is checked the presence of blood) was to be performed 3 times. A review of the ADL summary indicated Resident #14 had a medium incontinent stool on 5-5 between 8 p.m. and midnight. There was no indication the stool was hemetested. A review of the ADL summary indicated	F0502	Plan of Correction F502 1.Resident #14 was unable to provide another specimen prior to her discharge on 5-11-2012. 2.All other resident orders were reviewed and there were no other residents on the unit that had orders for hematest stools. 3.Process was developed for ordering, collecting and communicating specimens needed for testing. (See document #1) 4.Educator will inservice staff regarding ordering, collecting and communicating specimens needed for testing. (See document #2) 5.Quality Monitoring: 1.Monthly QI monitoring/data collection form was developed. (See attachment #3) 2.ADON will monitor all hematest stool orders each month. 3.QI monitoring results will be trended, reported, discussed and follow up initiated at QI meetings. 4.QI Team will determine when monitoring can be decreased to quarterly when 100% compliance is reached, not less than six months of observation.	06/08/2012

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	Resident #14 had a large incontinent stool on 5-6 between noon and 6 p.m. There was no indication the stool was hemetested. A review of the ADL summary indicated Resident #14 had a medium incontinent stool on 5-6 between 8 p.m. and midnight. The stool was hemetested negative. A review of the ADL summary indicated Resident #14 had a medium incontinent stool on 5-7 between 8 p.m. and midnight. There was no indication the stool was hemetested. A review of the ADL summary indicated Resident #14 had a hard formed stool on 5-8 between 8 p.m. and midnight. There was no indication the stool was hemetested. In an interview on 5-10-2012 at 1:38 p.m., RN #1 indicated it was difficult to obtain hemetests on incontinent stool because of possible contamination, but the hemetest should have been obtained on the formed stool on the 8th. A policy and procedure titled, "Occult Blood Stool Collection (Hemoccult Sensa)," dated 07-2009, indicated triplicate samples should be tested on three successive days. The policy also			

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	indicated samples were not to be collected if blood was visible. The policy did not indicate any other reason to refrain from completing the test. 3.1-49(a)			